1 INTRODUCTION AND HIGHLIGHTS OF FINDINGS

Health and Health Care of the Medicare Population: Data from the 1996 Medicare Current Beneficiary Survey is the fifth in a series of Medicare beneficiary sourcebooks. The information presented here is drawn from the Medicare Current Beneficiary Survey (MCBS), a rotating panel survey of a nationally representative sample of aged and disabled Medicare beneficiaries. The MCBS is sponsored by the Health Care Financing Administration (HCFA), under the general direction of its Office of Strategic Planning. Westat, a survey research organization with offices in Rockville, Maryland, is collecting and disseminating data for the first 10 years of the survey.

The MCBS is a comprehensive source of information on the health status, health care service use and expenditures, health insurance coverage, and socioeconomic and demographic characteristics of aged and disabled Medicare beneficiaries. Survey data are collected three times each year over 4 years regardless of whether the beneficiary lives in a household or a long-term care facility. The resulting data are disseminated in annual public use files (PUFs) containing a cross-section of all persons entitled to Medicare during the year. The 1996 MCBS, for example, includes beneficiaries who were entitled to Medicare for all or part of the year, as well as beneficiaries who died in 1996. These data can be used for cross-sectional analyses, or linked to PUFs from previous years for longitudinal analyses of the Medicare population.

One of the strengths of the MCBS is its scope of information on personal health care utilization and expenditures. Respondents are asked about expenditures on Medicare-covered services and health services not typically covered by the Medicare program. Those services typically not covered by Medicare include purchases of prescription medicines, dental care, hearing aids, eyeglasses, and long-term care facility services. The MCBS also collects information on out-of-pocket payments, third party payers, and use of health care services provided by such agencies as the Veterans Administration to more fully understand the financing of services not covered by Medicare. This information is used in conjunction with Medicare claims data to determine the amounts paid by Medicare, Medicaid, other public programs, private insurance, and households for each medical service reported by a beneficiary.

Annual data from the MCBS are released to the public in two different PUFs. The Access to Care PUFs, available for calendar years 1991 through 1998, contain information on beneficiaries' access to medical providers, satisfaction with health care, health status and functioning, and demographic and financial characteristics. The files include Medicare claims data for beneficiaries who were enrolled in Medicare for the entire calendar year and were community residents (that is, the noninstitutionalized population).[1] They provide a snapshot of the "always enrolled" Medicare population, and can be used to analyze characteristics of beneficiaries who were potential or actual users of Medicare-covered services during the entire 12-month period.

The Cost and Use PUFs, available for calendar years 1992 through 1997, are more comprehensive than the Access to Care PUFs. The Cost and Use PUFs include information on services not covered by Medicare, and the samples are chosen to represent all beneficiaries who were ever enrolled in Medicare at any time during a calendar year. The Cost and Use PUFs also contain detailed information on health insurance coverage, as well as health status and functional capacity. The data can be used to analyze total and per capita health care spending by the entire Medicare population, including part-year enrollees and persons who died during the year.

The MCBS sourcebooks include information from both sets of PUFs. The 1996 sourcebook also uses data from previous PUFs. Chapter 2 contains information on emerging trends and patterns between 1992 and 1996. It has sections on growth in personal health care spending by Medicare beneficiaries, health insurance, income inequality in the Medicare population, the correlation between health and socioeconomic status, access to care, and satisfaction with health care. Chapter 3 contains the same set of the

[1] Beneficiaries who did not live in long-term care facilities are referred to as community residents in the sourcebook.

cross-sectional data from the Access to Care and Cost and Use PUFs as previous sourcebooks. The 1996 sourcebook has changed the format of Section 6 data tables to highlight emerging trends in health and health care utilization between 1992 and 1996. The sourcebook now presents annual rates of change instead of differences between net estimates.[2] Annual rates of change provide an accurate ratio measure of growth and decline between the years.

Appendix A provides a description of the sample design, survey operations, response rates, and structure of the MCBS PUFs. It also includes a discussion of procedures to calculate standard errors for cross-sectional statistics and estimates of net change over time. Appendix B contains a glossary of terms and variables used in the detailed tables.

HIGHLIGHTS OF FINDINGS

Personal Health Care Expenditures

- Personal health care expenditures (PHCE) by Medicare beneficiaries expanded from $247 billion to $356 billion between 1992 and 1996. The 9.6 percent average annual rate of growth in health care spending by Medicare beneficiaries was more than three times that of the non-Medicare population. Health care for the non-Medicare population rose from $494 billion to $568 billion between 1992 and 1996.

- Per capita expenditures increased more rapidly among Medicare beneficiaries than among the non-Medicare beneficiaries. Between 1992 and 1996, the average expenditure by Medicare beneficiaries increased from $6,716 to $9,032, an annual growth rate of 8 percent. In contrast, the average expenditure in the non-Medicare population increased from $2,163 to $2,401, an annual growth rate of 3 percent.

- In 1996, growth in PHCE by the Medicare population decelerated for the first time in the decade, declining from a two-digit annual growth rate in previous years to 7 percent. The growth rate of per capita spending on health care slowed even more, averaging 5 percent for Medicare beneficiaries in 1996, down from 9 percent in 1995.

- In 1996, prescription medicine expenditures grew the fastest, 15 percent, of the major types of medical services consumed by Medicare beneficiaries. Despite growth spurts in 1994 and 1995, combined ambulatory care services grew more slowly in 1996. In 1996, however, ambulatory care services ranked top in shares of total PHCE, outweighing inpatient services. Spending in home health care also saw major decelerations in growth, dropping to 7 percent in 1996 from 36 percent in 1994.

- Funding sources for health care for both the aged and disabled persons remained remarkably stable over the 5-year period. The main payers were Medicare (55%), households (19%), Medicaid (12%), and private insurance (10%). The share paid by Medicare may be slightly overstated relative to other payers because the MCBS uses Medicare claims to supplement household-reported information on health care utilization and expenditures. Comparable information is not available for services that are not covered by Medicare.

Medicare Beneficiary Income

- The proportion of elderly beneficiaries living in poverty has declined significantly since the early 1960s. Beneficiary income continued to improve between 1992 and 1996. The median annual income of aged beneficiaries living in communities grew 25 percent, from $14,400 to $18,000. After adjusting for inflation, these beneficiaries had a substantial gain of 13 percent in real income during this period.

[2] See Appendix B for an explanation of annual rate of change.

Financial gains by the elderly community residents disguise a substantial degree of income inequality within the Medicare population. Beneficiaries in the highest income quartile had 57 percent of the total income reported by Medicare beneficiaries, while the lowest income quartile had 7 percent of the total. The income distributions remained relatively stable between 1992 and 1996, although those beneficiaries with the highest income showed slightly larger income gains during this time period.

Among community residents, race and education appear to have a strong influence on income. Non-Hispanic whites had significantly more income than did non-Hispanic blacks or Hispanics. In addition, the income of non-Hispanic whites grew faster than that of other racial and ethnic groups between 1992 and 1996. Education had a significant effect on the financial well being of beneficiaries, as the best-educated beneficiaries reported several times more income than their less educated counterparts.

Health and Socioeconomic Status

Low-income beneficiaries living in communities were more likely to have health problems than their high-income counterparts. Over 37 percent of beneficiaries in the lowest income quartile, compared to approximately 15 percent in the highest quartile, reported that they were in poor or fair health.

Beneficiaries with low income were more likely to report at least one limitation in Activities of Daily Living (ADLs). A beneficiary with at least one such limitation was more than twice as likely to be in the lowest income quartile as opposed to the highest income quartile (29 percent versus 12 percent, respectively).

The relationship between health and socioeconomic status also is reflected in significant differences in prevalence of diseases reported by higher- and lower-income beneficiaries. In 1996, beneficiaries in the lowest income quartile had the highest prevalence of major diseases including Alzheimer's disease, diabetes, mental illness, osteoporosis, and stroke.

Health Insurance Coverage

Steady increases in Medicare HMO enrollment were accompanied by corresponding declines in private health insurance. Enrollment in Medicare HMOs jumped from 7 percent in 1992 to 13 percent in 1996, a two-fold increase in 5 years. On the other hand, enrollment in employer-sponsored private health insurance declined from 36 percent in 1992 to 34 percent in 1996, and individually-purchased private insurance declined from 38 percent to 34 percent.

Access to Care

Typically, Medicare beneficiaries experience few problems accessing health care. Most beneficiaries had a usual source of care, reported no difficulty in getting care, and did not delay care for financial reasons. Beneficiaries also reported a decline in barriers to care between 1992 and 1996, although some subgroups of the Medicare population had more than average difficulty obtaining medical care.

The more vulnerable Medicare beneficiaries, such as those with low income, disabilities, racial and ethnic minorities, and those without supplemental insurance (i.e., Medicare fee-for-service only beneficiaries), faced higher than average barriers to care. However, in recent years, access is becoming more equitable, as these vulnerable beneficiaries made better than average gains in access to health care between 1992 and 1996.

Disabled beneficiaries often reported greater barriers to health care than did other Medicare beneficiaries. They consistently experienced more difficulty in getting care, and delayed care more often due to cost.

- Beneficiaries with no supplemental insurance were least likely to have a usual source of care. Between 1992 and 1996, these beneficiaries did not increase their use of office-based physicians as a usual source of care. In addition, they consistently reported more access problems, such as delays in care due to cost and difficulty in obtaining care, than did other vulnerable subgroups of Medicare beneficiaries.

Satisfaction with Care

- Most Medicare beneficiaries appeared to be relatively satisfied with the quality of their general health care. Between 1992 and 1996, the percentage of community-only beneficiaries who were satisfied or very satisfied with their general health care increased from 88 percent to 92 percent. Satisfaction rates are even higher when beneficiaries who did not see a doctor during the year in question are excluded from the comparisons. In 1996, 96 percent of beneficiaries who saw a physician in that year reported being satisfied or very satisfied, up from 95 percent in 1992.

- The more vulnerable Medicare beneficiaries expressed below average satisfaction with their health care. Those least satisfied with their health care included disabled beneficiaries and Medicare fee-for-service only beneficiaries. In 1996, eight percent of disabled beneficiaries and 6 percent of the fee-for-service only beneficiaries still remained unsatisfied with their general health care. However, both groups reported increased satisfaction with their health care since 1992.

- The more vulnerable Medicare beneficiaries also were less satisfied than average with such dimensions of their health care as availability of care at night and on weekends, ease of getting to a doctor, and cost of care. The disabled and the fee-for-service only beneficiaries were the least satisfied. However, in general, the proportion of vulnerable beneficiaries expressing satisfaction with various dimensions of their health care increased between 1992 and 1996.

- Out-of-pocket cost was the least satisfactory dimension of health care. In 1996, 13 percent of community-only residents reported that they were dissatisfied with their share of health care costs. Fee-for-service only beneficiaries were least satisfied with cost, primarily because they face higher out-of-pocket expenses than other groups. Disabled beneficiaries were nearly as dissatisfied with cost as fee-for-service only beneficiaries. Nevertheless, satisfaction with cost increased by 14 percentage points in both groups between 1992 and 1996.